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TO THE EDITOR: I was pleased to read Olsen and colleagues' article regarding the need for do-not-resuscitate (DNR) orders in the home so that paramedics are not forced, because of legal mandates, to disregard a patient's autonomy.[1] Recently we admitted a 52-year-old woman with advanced metastatic breast carcinoma to our intensive care unit, intubated her, and initiated pressor agents despite her well-known and documented desire not to be resuscitated.

This patient, a member of the Hemlock Society, also had a durable medical power of attorney and had left a handwritten note saying that she wanted to die. She was found by paramedics in her home with agonal respirations. After a frenzied series of phone conversations, including some with the city attorney's office and local police departments, the paramedics were advised that they were duty-bound to try to save her life. Had they not done so, they were told, they would have been subject to prosecution for abetting a suicide.

While intubated and unconscious, she developed a tension pneumothorax and had to have a chest tube thoracotomy done. After a painful and prolonged intubation and stays at two different hospitals, she finally went home, where she died about eight weeks after this unfortunate and somewhat callous saga had begun.

Under a new state law persons in Colorado now can reject cardiopulmonary resuscitation by signing a form received from their physician. The law was intended for terminally ill patients who prefer to die at home instead of being rushed off to a hospital. Another facet of this dignified measure is to protect emergency personnel when they are faced with patients who clearly do not want treatment to prolong their agony. The State of Colorado has heeded the exhortation of these authors to establish a viable system for home DNR orders in their communities. Patient care will be truly enhanced through the widespread acceptance of this system.

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REFERENCE

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Dr Lowenstein Responds

TO THE EDITOR: We appreciate the opportunity to respond to these letters. It is encouraging to learn from Dr Mehler and Dr Harding that other states, counties, and municipalities are working to develop prehospital do-not-resuscitate (DNR) policies. Harding has outlined in detail several important barriers to implementing prehospital DNR policies—proof of patient identification, the need for patients to wear wristbands or bracelets, the ambivalence of family members who call 911, the needs that patients and family members sometimes have to change their minds, and conflicting policies and protocols that arise when different paramedic units cross county and city lines.

As Mehler mentions, since we conducted our study in Colorado, the Colorado legislature has passed legislation and the Colorado Medical Society has developed a detailed protocol to implement home DNR orders. The program is new. It is already evident, however, that implementation will face some obstacles. Physicians throughout the state must be sent educational material describing the legislation, the rationale for the program, and the means to secure at-home DNR orders for their patients. Fundamental changes in paramedic protocols must take place. Efforts must be made to coordinate home DNR orders with existing emergency department and inpatient do-not-resuscitate protocols. Citizens throughout the state must be made aware that they can request home DNR orders, that they must sign special documents, and that they can also purchase wrist bracelets that say "do not resuscitate" and that contain their name and identifying information. In addition, given the cost of the DNR bracelets—currently $27—a means must be found to assist indigent patients to purchase them. Finally, as with any new health care policy, it is essential to collect data to analyze the effect on patient care and comfort.

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The Potential Effects of Enterprise Liability

TO THE EDITOR: The term enterprise liability, unknown to most physicians until the past few months, is seen with increasing frequency in the medical and public press. The concept is not new—airline pilots and employed physicians have long been protected from liability for their errors and omissions by primary accountability of an airline or health plan.

What is new, and particularly important to physicians in private practice, is the application of "enterprise liability" to hospitals.

Hospital liability, though not yet required by any state legislature, is recommended and best described in Paul Weiler's book, *Medical Malpractice on Trial*,[1] as one of four proposals to counter the "malpractice problem." If this proposal is implemented, hospitals will be liable for negligence by medical staff members; physicians will not be legally responsible for negligent actions. The supposed deterrance factor of malpractice law will be shifted from the physician to the hospital, giving a hospital moral and economic clout to evaluate, assess, and discipline physicians to a degree far beyond current medical staff oversight.

Much that is now written of enterprise liability relates to its application to managed care entities, such as health maintenance organizations, where, in many instances,